Treating Anxiety Disorders in a Managed Care Environment

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Brief Therapy for Human Services Workers

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Organization

- Principles of Managed Care
- Nature of Anxiety
- Treating Anxiety Disorders: A Managed Care Perspective
- Treating Specific Anxiety Disorders
- Becoming Proactive

●Principles of Managed Care

Nature of Insurance Business

- Shared risk based on actuarial tables
- Competitive Pressures
  - From other insurance companies
  - From purchasers of insurance (90% are businesses)
  - From stock holders
- No tangible product
  - Essentially a buying service

Why Managed Care?

- Response to the competitive pressures
  - Need to offer an enhanced service for the money
  - We provide the service
  - Therefore, we are the one's pressured to provide more for less
- Mental health services are now a significant part of health care costs

Principles of Managed Care

- Two guiding principles
  - Control costs
  - Provide quality service
- No managed care company can compete in the long term unless both principles are met
- It is not unusual for these to be out of balance during the shake-out phase

Controlling Costs

- Enforce policy limits on what is covered
  - Exclude "medically unnecessary" treatment
- Efficient and appropriate service
  - Screen for critical issues (e.g., substance abuse)
  - Problem-focused treatment
  - Empirically-validated treatment procedures
- Pressure providers to work faster

How do we prosper?

- Sharp, thorough client assessments
  - backed by specific data
  - with a focus on functional deficits
- Clear, specific, and appropriate treatment goals
- Selection of empirically-validated treatment procedures
- Plan for monitoring progress

- Principles of Managed Care
- **Nature of Anxiety**

Anxiety

- Not, by itself, a problem
  - Anxiety is not only normal, it is helpful
  - Need to distinguish between
    - Functional anxiety
    - Debilitating anxiety
- Triggered by uncertainty about whether we can handle a situation
- Learned quickly; unlearned slowly

Anxiety Disorders

- Defined by being
  - too intense, too frequent, or inappropriate
  - interfering with functioning
- NOT defined by discomfort level
- Now recognize many different kinds of anxiety disorders

Types of Anxiety Disorders

- Specific Phobia (e.g., fear of heights)
- Panic Disorder (often with agoraphobia)
- Obsessive-Compulsive Disorder
- Social Phobia (e.g., public speaking anxiety)
- Generalized Anxiety Disorder
- Posttraumatic Stress Disorder

- Principles of Managed Care
- Nature of Anxiety
- **Treating Anxiety Disorders: A Managed Care Perspective**

Medical Necessity

- The FIRST hurdle in getting approval for treatment
- Rarely defined explicitly
- Most companies appear to define this in terms of functional disability
- Availability of empirically-validated treatments for the condition also considered

Functional Disability

- Definition: Inability to perform one or more functions expected of the client in his or her situation
  - Fear of heights is more dysfunctional for a roofer than for a teacher
  - Public speaking anxiety is more dysfunctional for a teacher than for a roofer
- Treatment should always focus on reducing functional disability

Diagnosis

- Explicit diagnosis with data to back it up
  - e.g., "Excess anxiety" does not fly as well as a diagnosis of "social phobia"
- Link diagnosis to:
  - the functional disabilities experienced by your client
  - the treatment plan
  - the criteria for successful outcome

Treatment Plan

- Everything must be explicit
  - Specific treatment technique
  - Specific focus for the treatment
  - Specific criteria for evaluating effectiveness
- Empirically-validated treatments
- Attention to the appropriateness of the plan for the client that you are treating

"Kiss-of-Death" Phrases

- Avoid these phrases
  - "Working through . . ."
  - "Exploring (or processing) their issues"
  - "Increase their insight into . . ."
- The problem is NOT the dynamic nature of these phrases, but rather, their lack of specificity and failure to link to the goal of reducing specific dysfunctions

Termination Criteria

- Always more issues to work through
  - So, how do you decide that treatment is no longer "medically necessary"
- Best to link termination criteria to the explicitly defined functional disabilities
- Never lose site of these
  - The single most important issue in dealing with managed care

Periodic Reviews

- Continuity in your treatment plan and goals
- Clear indication that you are monitoring progress
  - Focus on the functional disabilities
- More "kiss-of-death" phrases
  - "Building rapport"
  - "Laying the groundwork"

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Specific Treatments

- Treatments covered
  - Panic disorder with agoraphobia
  - Obsessive-Compulsive Disorder
  - Specific Phobias
  - Social Phobias
- Overview of treatments only
- References to more specific information for each treatment covered

Panic Disorder

- Characterized by:
  - Occasional to frequent panic attacks
  - Secondary anxiety about having more attacks
  - Secondary anxiety drives agoraphobic avoidance of situations
- First recognized in DSM-III (1980)
- Once called "anxiety attacks"

Managed Care Points

- Medical necessity (generally accepted)
- Functional disability
  - Easy to establish if their is agoraphobia
- Empirically-validated treatment
  - Both medication and cognitive-behavioral treatments exist
- Termination criteria
  - Reduce panic and agoraphobic avoidance

Secondary Diagnoses

- Depression
  - "Feeling of helplessness" as a recipe for depression
  - Mild depression is ubiquitous
  - Major depression should be treated first
- Alcohol of drug abuse
  - Sometimes a self-medication strategy
  - Should be treated first

MAP Program

- Most comprehensive empirically-validated treatment
  - Barlow & Craske (Greywind Publications)
- Key components
  - Education about nature of panic
  - Specific anxiety control strategies
  - Gradual exposure to feared situations
  - Desensitization to body sensations

Nature of Panic

- Fight or flight response
  - A false alarm
  - NOT dangerous
  - Symptoms explainable
- Produces secondary anxiety
  - Drives the agoraphobia
  - Increases the sensitivity of panic trigger
  - Primary focus of treatment

Anxiety Control Techniques

- Education
  - Reduces fear of the unknown
- Physiological control
  - Breathing exercises
  - Progressive muscle relaxation
- Cognitive control
  - Relabeling experiences
  - Distraction from disruptive cognitions

Exposure

- Gradual exposure (in vivo)
- Emphasize anxiety control techniques
  - breathing and cognitive techniques
- "Safe person" can facilitate exposure initially, but needs to be phased out
- Some exposure may require that you leave the office
- Exposure homework

Physiological Desensitization

- Panic patients often become hyper-sensitive to their own physiology
  - Small, and perfectly normal, physiological changes are viewed as threatening
  - May be sufficient to trigger a panic attack
- Deliberate exposure to these sensations reduce our sensitivity to them

Relapse Prevention

- Panic patients, even after successful treatment, remain prone to panic attacks
- Attention to strategy for dealing with future attacks
  - Needs to be over-learned to actually work
  - Sequence the responses learned during the treatment

Obsessive-Compulsive Disorder

- Characterized by:
  - Thoughts (obsessions) that are both unwanted and uncontrollable and that cause considerable anxiety
  - Behaviors (compulsions) designed to neutralize or minimize the impact of the obsessions
- Does not include appetitive behaviors like compulsive spending or gambling

Managed Care Points

- Medical necessity (generally accepted)
- Functional disability
  - Focus on time symptoms consume, reduced performance, and avoidance
- Empirically-validated treatment
  - Medication and behavioral treatments exist
- Termination criteria
  - Reasonable control of symptoms

Exposure with Response Prevention

- Only psychological technique with demonstrated efficacy
- Developed by Edna Foa and Colleagues
  - Steketee (Guilford Press)
- Key elements
  - Challenging obsessions by inviting them and then preventing the compulsions

ERP Approach

- Identify the current obsessions and compulsions
- Select a suitable starting point
  - Moderately challenging
  - If possible, one that you can coach
- Have the client do the exposure while trying to avoid doing the compulsion
  - Client does the response prevention

Repeated Exposure

- Exposure Process
  - A single exposure produces minimal change
  - Repeated exposure is needed
  - ERP become more efficient with each OCD symptom that is encountered
- OCD is controlled, rarely cured
  - Client has to be prepared to do ERP with each new symptom that develops

Specific Phobia

- Fear of a specific object or situation
  - Fear of specific animals
  - Fear of heights or flying
  - Must differentiate from agoraphobia that is secondary to panic
- May or may not be disruptive to the person's life

Managed Care Points

- Medical necessity (depends)
- Functional disability
  - What is avoided at what cost to client?
- Empirically-validated treatment
  - Desensitization (systematic or in vivo)
- Termination criteria
  - Fear and avoidance reduced or eliminated

Desensitization

- Types of Desensitization
  - Systematic (imaginal exposure)
  - In Vivo (actual exposure)
- Although original counterconditioning explanation is questionable, we still use anxiety control techniques
- Flooding is also an option

Social Phobia

- Fear of "performing" in public
  - e.g., public speaking or eating in public
- Some clients are willing to make career and life decisions to avoid these phobias
- May be long-standing or may develop following a traumatic event

Managed Care Points

- Medical necessity (depends)
- Functional disability
  - Focus on cost to client of avoiding the phobic situation
- Empirically-validated treatment
  - Cognitive-behavioral treatment available
- Termination criteria
  - Ability to perform with acceptable anxiety

Social Effectiveness Therapy

- Actually a general approach that includes
  - Social skills training
  - Anxiety management
  - Exposure
- The emphasis on social skills is critical in most cases

Example: Public Speaking

- Skills training
  - Organizing, rehearsing, and presenting
- Anxiety management
  - Usually breathing and cognitive techniques
- Exposure
  - Rehearsal for you or for a camera
  - Presentations to audiences (possibly using groups like Toastmasters International)

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Why Managed Care?

- Reasons
  - Spiraling costs
  - No previous quality-assurance procedures
- Managed care would not exist if it were not for third party reimbursement
  - If client is paying out-of-pocket, client is managing his or her own care and judging the cost effectiveness of the treatment

Dealing with Managed Care

- Recognize their values and what they will support
  - Limit treatment to "medically necessary," which usually means serious functional disabilities present
  - Focus on functional disabilities primarily
  - Seek to use most efficient treatment
  - Show in your language that you understand what they are doing

Alternatives to Managed Care

- Not everyone who could benefit from psychotherapy is sick (i.e., required "medically necessary" treatment)
- Therapy as a growth process
  - Funded much like continuing education
- If costs are right AND benefits are likely, people will pay out-of-pocket for growth-oriented therapy

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Summary

- Managed Care wants effective, short-term, problem-focused therapy for problems that cause significant dysfunction for the client
- Anxiety disorders, and the treatments available for them, meet these criteria
- You can work with managed care IF you remember what they are after